New Jersey Department of Health and Senior Services
Office of Research and Development

QUARTERLY CARDIAC PROGRAM REPORT

This form must accompany each quarterly data submission.

Name of Hospital		
Hospital Medicare Provider Number		Hospital Division Code
Year of Data	Quarter of Data *(Check one)* ☐ 1st Quarter ☐ 2nd Quarter ☐ 3rd Quarter ☐ 4th Quarter	
Program *(Check one)* ☐ Low Risk Cardiac Catheterization ☐ Full Service Cardiac Catheterization ☐ Open Heart Surgery		

Please list below the names and license numbers for the "Director" and "Other Physicians" who performed procedures in the "checked" program during the quarter. To assure that physicians are properly credited with their total volume of procedures performed, make certain that every physician name and license number is an exact match with your data file.

Director's First Name	Director's Last Name	Director's Medical License Number

Physician's First Name	Physician's Last Name	Physician's Medical License Number

Name of Individual Completing Form *(Please Print)*	Telephone Number
Signature of Director (Mandatory)	Date